



John Elias Baldacci
Governor

STATE OF MAINE
DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF ELDER AND ADULT SERVICES
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11 STATE HOUSE STATION
AUGUSTA, MAINE
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John R. Nicholas
Commissioner

MaineCare Home Health Referral Attachment (Age 21 and over)

Member: _____

MaineCare #:

Section 40.02-3

- Attached is the Form HCFA-485 Plan of Care signed by the member’s physician. The member’s physician signed and certified a plan of care that safely and appropriately treats the member’s medical condition. **OR**
- Attached are physician orders for the plan of care at time of discharge. The member is located in a hospital.

AND

- These services are not available and safely accessible to the member on an outpatient basis.
 - Medically contraindicated with likelihood of a bad result.
 Specify reason: _____

_____. **AND**

- The member’s condition requires skilled nursing care on a “part-time” or “intermittent” basis, or physical, occupational, or speech therapy as defined in Section 40.02-3 (E).

Prior Authorization required: Check the category of service that you are requesting Goold Health Systems to prior authorize for this member.

- Member requires additional certification period for unstable medical condition for continued assessment and management of skilled services as defined in Section 40.06-E.

Start of Care Date: ___/___/___

- Member requires continued home health services.
- Member appears to be Nursing Facility level of care.
- Prior Authorization is needed to add additional services to Section 17 plan of care.

Person completing this form: _____

Date: _____

Provider Name: _____